South Central MIRECC

Reducing mental health disparities among rural veterans

Communiqué

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INSIDE THIS ISSUE

The next issue of the *South Central MIRECC Communiqué* will be published November 2, 2010. Deadline for submission of items to the November newsletter is October 28, 2010. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Ashley McDaniel, at Ashley.McDaniel@va.gov

South Central MIRECC Internet site: www.mirecc.va.gov/visn16

National MIRECC Internet site: www.mirecc.va.gov

OKLAHOMA CITY VAMC'S FAMILY MENTAL HEALTH PROGRAM SERVING VETERANS AND THEIR FAMILIES FOR OVER 30 YEARS

By Michelle Sherman, Ph.D., Ursula Bowling Psy.D., Alan "Dutch" Doerman, Psy.D., ABPP, and Lee Thrash, Ph.D.

The Communiqué asked Dr. Sherman and her team to describe their work in the Family Mental Health Program

The Oklahoma City VAMC's (OKCVAMC) Family Mental Health Program was created in 1978 by Mark Cohen, Ph.D. (1978-1984), who was succeeded by Richard Carothers, Ph.D. (1984-1996). Drs. Cohen and Carothers established a healthy referral base from providers across the medical center, and provided couples and family therapy to primarily Vietnam and WWII era Veterans and their families. Dr. Carothers endeared himself to Veterans, their families and clinical trainees through his love of experiential activities, such as "group juggle," Jenga, and the infamous rubber chicken. Michelle Sherman, Ph.D. followed in their footsteps as director (1997-present), also providing couples and family therapy. Over the past 14 years, the Family Mental Health Program has grown in staffing and now provides a wider range of services to Veterans and their families, including:

Michelle Sherman, Ph.D., Director of the OKC Family Mental Health Program.

COUPLES/FAMILY THERAPY

Couples/family therapy is provided in a variety of settings. Ursula Bowling, Psy.D. is currently the primary provider of couples/family therapy. She receives referrals from medical and mental health clinicians, and she provides clinical supervision and didactic training to psychology post-doctorates and interns, psychiatry residents, and medical students.

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OKCVAMC Family mental health program continued…

SUPPORT AND FAMILY EDUCATION (SAFE) PROGRAM
Created by Dr. Sherman in 1999, this 18-session family education curriculum is designed to support adults who care about someone living with serious mental illness or PTSD. Dr. Sherman provides training and consultation on program implementation. VA Central Office has designated this program a "best practice" in family education. Creation of a manual for providers desiring to offer the SAFE program at their own facilities was funded by a SC MIRECC clinical education grant. Curriculum is available free online at www.ouhsc.edu/safeprogram.

JOURNEY THROUGH LOSS
Started in 2000, this is a 6-week psychoeducational support group for Veterans and/or their family members who have lost a loved one. The Journey Through Loss program was created by Dr. Sherman and is currently facilitated by Dr. Bowling.

MEMORIAL SERVICES
Begun in 2000, these quarterly services are provided for family members, Veterans and OKCVAMC staff to honor and remember Veterans cared for in the facility who have recently passed away. This program involves many services across the medical center (e.g. chaplain, psychology, social work, emergency medical services, etc.). Dr. Sherman is the committee chair and host of the services.

US AND THEM: THE EXPERIENCE OF MENTAL HEALTH STIGMA (2004)
Funded by a SC MIRECC clinical education grant, Dr. Sherman performed qualitative research with Veterans seen in mental health, their families, and mental health providers to explore the role of stigma in VA mental health clinics. A resource packet containing a PowerPoint presentation to encourage reflection among providers, accompanying participant guides, sample therapy sessions to encourage Veterans to discuss issues of mental health stigma, and a bibliography list is available from the SC MIRECC.

OPERATION ENDURING FAMILIES (2007)
This 5-session family education program (Bowling, Doerman & Sherman) is a modification of the SAFE Program for OIF/OEF Veterans and their families. It addresses common issues after deployment, including reintegration, communication skills, and managing anger. Development of the manual was funded by a MIRECC clinical education grant. The curriculum is available online for providers who want to offer the program at their own facilities at www.ouhsc.edu/oef.

REACHING OUT TO EDUCATE AND ASSIST CARING, HEALTHY FAMILIES (REACH) PROGRAM
Funded in 2005 by VA Central Office with Mental Health Enhancement Funds, the REACH program is our adaptation of the evidence-based multifamily group psychoeducation program created by Dr. William McFarlane of the Maine Medical Center Research Institute. Numerous modifications were made to meet the needs of our Veterans, specifically individuals with PTSD. In 2006, Alan "Dutch" Doerman, Psy.D., ABPP, and Lee Thrash, Ph.D., were hired as REACH team psychologists, both of whom serve as lead clinicians on this intervention. A longitudinal quantitative evaluation of the REACH Program is directed by Ellen Fischer, Ph.D., with assistance from Richard Owen, M.D., Silas Williams, and Xiaotong Han, M.S. Dr. Thrash is also a national trainer for the VA Office of Mental Health's rollout of the Multifamily group trainings.

ADJUSTMENT TO TRAUMATIC STRESS (2008)
In collaboration with other OKCVAMC psychologists, Drs. Doerman and Thrash created this introductory psychoeducational class for Veterans and their family members. The 4-session class meets weekly and addresses common responses to trauma and treatment options at the OKCVAMC. Drs. Thrash and Doerman are the primary instructors for this course.

VETERAN PARENTING TOOLKIT (2010)
Drs.Sherman, Bowling, Anderson, and Wyche created this toolkit with funding from a SC MIRECC clinical education grant. These five age-based toolkits for OIF/OEF Veterans and their partners explain how to reconnect with your child after deployment, take care of yourself as a parent, reconnect with your partner, and know when to and how to access additional resources as needed. Providers may print the toolkits out to give to Veterans and families or simply provide the website, www.ouhsc.edu/VetParenting.

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WORKING WITH COUPLES TRAINING

With the direction and support of Drs. Michael Kauth and Kathy Henderson, Drs. Sherman, Bowling and Doerman developed and taught two VISN 16 trainings in 2009 for clinicians on Working with Couples. We are now participating in the creation of an SC MIRECC funded online interactive platform of this Working with Couples training, due out in 2011.

In addition to the creation and evaluation of curricula and programs, the Family Mental Health Program is actively involved in various research projects focusing on family issues and PTSD. Current projects include:

- Collaboration with Betty Pfefferbaum, M.D., J.D., of the University of Oklahoma Health Sciences Center, on SC MIRECC-funded longitudinal study of children and wives of deployed Oklahoma National Guard troops;
- Collaboration with Ellen Fischer, Ph.D. and colleagues on an HSR&D funded two-site qualitative study of the needs and preferences of OIF/OEF Veterans and families about involving families in care, and
- Drs. Sherman/Bowling/Fischer/Peggy Hudson/Russell Smith collaboration on a VA Office of Rural Health funded qualitative study of the needs/preferences of rural Veterans, families, and providers about family education.

Other essential and greatly appreciated teammates in our Family Mental Health Program include Shavon Toles (REACH Program Support Assistant), Brad Townsend (REACH Psychology Technician), Linda Muse (OKC MIRECC Program Support Assistant) and Deb Croft (Program Support Assistant).

We would enjoy an opportunity to exchange ideas and collaborate with clinicians who share our passion for caring for America's Heroes in the couple/family arena.■

Visit the Ask the Expert section of the VISN 16 Mental Health Providers Community of Practice website from a VA computer at http://vaww.visn16.portal.va.gov/SiteDirectory/mhp/AsktheExpert/default.aspx to submit your questions to the authors or participate in the article discussion group.

RURAL HEALTH RESEARCH UPDATE

ARE RURAL HEALTH CLINICS PART OF THE RURAL SAFETY NET? (POLICY BRIEF)

Rural Health Clinics (RHCs) are an important part of the rural health care infrastructure, providing a wide range of primary care services to the rural residents of 45 states. Since RHCs are located in underserved rural areas and serve vulnerable populations, many consider them safety net providers. This paper explores whether and to what extent independent RHCs are serving a safety net role, or have the capacity to serve that role.

Key Findings: 86% of independent RHCs offer free care, sliding fee scales, or both; 97% were currently accepting new Medicaid/SCHIP patients; RHCs' patient mix has a higher proportion of Medicaid/SCHIP patients in counties not served by a federally funded Community Health Center (CHC). Lacking the grant funds and federal technical assistance provided to CHCs to build service capacity, few RHCs have had the resources to expand their scope of services. The Affordable Care Act has made it clear that partnering with CHCs is an option for RHCs that find themselves serving safety net populations. More study is needed laying out the details of such arrangements, the reimbursement and governance implications, and the relative advantages and disadvantages from the perspectives of the CHC, the RHC, the physician, and especially, the patient. For more information, contact David Hartley, PhD, Maine Rural Health Research Center, Phone: 207-780-4513, davidh@usm.maine.edu. To download a copy of this policy brief, visit http://muskie.usm.maine.edu/Publications/rural/WP43/Rural-Health-Clinics-Safety-Net.pdf.

SC MIRECC COMMUNIQUÉ NAMES NEW EDITOR

Interviewed by Carrie Edlund, M.S., M.A.

The SC MIRECC would like to welcome Ashley McDaniel, MA, as the new editor of the Communiqué Newsletter. Carrie Edlund spoke with Ms. McDaniel about her new position.

What is your background and how has that prepared you to edit the Communiqué?

I have a B.A. in Public Relations and an M.A. in Organizational and Interpersonal Communication, as well as five years' experience with the SC MIRECC, as a research technologist and as a technical writer. I helped administer Dr. Greer Sullivan's CALM: Improving Primary Care Outcomes research study and assisted Mary Sue Farmer, former *Communiqué* editor, with layout design and content development. I chose the communications field because I'm particularly interested in the theory of how and why people communicate with each other, and how those relationships can be improved. I completed my M.A. in interpersonal and organizational communication to continue to learn about communication theory, how to manage communication crises, and how to perform organizational assessments. Skilled people can do important work, but if they can't communicate the results of that work to other people in ways that enhance collaboration, the knowledge doesn't get shared. That's why publications like the *Communiqué* can be so valuable—they help SC MIRECC stakeholders connect and share information.

Do you anticipate any editorial changes to the Communiqué?

Though I hope that our audience has been pleased with the design changes they have seen in the newsletter over the last year and a half, I hope to introduce even more changes to the newsletter by using other software, such as Adobe. I would like to improve our use of space so that we can pack more articles and information into each issue without increasing the number of pages.

The SC MIRECC is embracing the VA's use of web-based technology to interact with internal and external stakeholders, such as professional networking, clinical care and education provided over the internet. In September, we launched the VISN 16 Mental Health Providers Community of Practice website. As the webmaster, I help facilitate forum discussions and post helpful educational materials and resources. I will also feature stories from the *Communiqué* newsletter in the Ask the Expert section of website. Starting this month, readers with VA computer access can visit http://vaww.visn16.portal.va.gov/SiteDirectory/mhp/AsktheExpert/default.aspx to participate in discussion groups about featured articles and ask questions to the authors and other experts.

Who is your target audience for the Communiqué?

The newsletter reaches a wide audience of frontline mental health clinicians and program managers, mental health administrators, medical center management, network management, other networks, other MIRECCs and Centers of Excellence, VA Central Office, and the chairs of psychiatry at our affiliated Universities.

What role do you think the Communiqué plays in the professional lives of your readers?

I hope our readers find the articles informative and practical. We work hard to produce articles that enhance research, education, and clinical care. This year we have invited CBOC and VAMC providers to submit articles that describe their mental health care programs and best practices. Because the VA is so large, our experiences vary greatly from rural to urban areas and between states. We want to highlight what everyone is doing. I also hope that readers have a personal stake in newsletter content. I invite them to submit story ideas or announcements any time for the newsletter or the NewsFlash email alerts to Ashley.McDaniel@va.gov.

Which article has had the most impact on you personally?
Dr. Elise Taylor's article about the Tulsa Drug Treatment Court in the March 2009 issue has had the greatest impact on me so far.

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I like this intervention program because it helps Veterans in the criminal justice system dealing with mental health and substance abuse issues improve their lives. This is especially important for returning OEF/OIF Veterans attempting to readjust to civilian life. A few months after this issue, Dr. JoAnn Kirchner's ACCESS project developed a Veteran's Treatment Court in Arkansas. I was able to visit the Tulsa treatment court with Mary Sue Farmer, the VTC program director, and members of the ACCESS project advisory committee to see the program in action. After the visit, I developed brochures and manuals for Arkansas program. It was an awesome experience.■

WEBINAR ON FAMILY EDUCATION IN CBOCS

Michelle D. Sherman, Ph.D. (OKC), Ursula Bowling, Psy.D. (OKC), Leigh Ann Johnson, MSW, LCSW (Biloxi), and Sharon Berry, LCSW (Pensacola)

With the support of the South Central MIRECC and the Office of Rural Health, VISN 16 collaborators recently completed a pilot study to better understand how the Support And Family Education (SAFE) program could best be tailored to the needs and preferences of rural Veterans, rural families, and providers in rural Community Based Outpatient Clinics (CBOCs).

The investigators will offer an hour-long webinar training for interested parties on implementing SAFE in rural areas/CBOCs **October 28, 2010 at 12:00-1:00 p.m. CST**. The webinar will include a summary of the research, review of the rural implementation toolkit, sharing by some VISN 16 CBOC providers about their experiences to date, and time for questions. They will also offer limited ongoing consultation to interested rural sites, if desired. To participate in the webinar visit www.ouhsc.edu/safeprogram and call **1-800-767-1750**. You will be prompted to enter the participant access code (**42035#**).

Note: Dr. Sherman is available to provide time-limited informal consultation for individuals who cannot attend the webinar. For more information, please email Dr. Sherman at Michelle.Sherman@va.gov. ■

OCTOBER CONFERENCE CALLS CALL-IN NUMBER: 1-800-767-1750		ACCESS CODE
6	MIRECC Site Leaders, 11:00 AM CT ***CANCELED***	27761#
12	MIRECC Leadership Council, 3:30 PM CT	19356#
14	National MIRECC & COE Education Group, 1:00 PM CT	28791#
19	VISN 16 Mental Disaster Team, 11AM CT	76670#
20	MIRECC Program Assistants, 2PM Central	43593#
25	MIRECC Education Core, 3:00 PM CT	16821#
26	MIRECC Leadership Council, 3:30 PM CT	19356#
28	National MIRECC & COE Implementation Science discussion, 2:00 PM CT	28791#

RECENT SC MIRECC PUBLICATIONS

HEALTHY IDEAS: IMPLEMENTATION OF A DEPRESSION PROGRAM THROUGH COMMUNITY-BASED CASE MANAGEMENT

Casado BL, **Quijano LM, Stanley MA, Cully JA**, Steinberg EH, Wilson NL

Gerontologist. 2008;48(6):828-38

Healthy IDEAS (HIDEAS; IDEAS stands for Identifying Depression, Empowering Activities for Seniors) is an evidence-based depression program addressing commonly recognized barriers to mental health care for older adults. The purpose of this study was to describe the implementation of HIDEAS and assess its feasibility. Three community agencies implemented the program with 94 eligible older adults who were identified from 348 screened older adults. Program implementation was assessed by using the Core Implementation Component framework, a client-tracking database, written survey of case managers, focus-group interview with coaches, and agency and project progress reports.

Several challenges were identified: clients' reluctance to acknowledge depressive symptoms and difficulty in engaging in behavioral changes; differences among case managers' mental health knowledge, skills, and "buy-in" and difficulty managing limited time; and differences in agency culture that foster in-agency supervision. Successful adoption and sustainability of HIDEAS are more likely when essential elements of the Core Implementation Component framework are addressed to bring about behavioral changes at all treatment-implementation levels--clients, practitioners, and organizations.

INAPPROPRIATE PSYCHIATRIC ADMISSION OF ELDERLY PATIENTS WITH UNRECOGNIZED DELIRIUM.

Reeves RR, Parker JD, **Burke RS**, Hart RH

South Med J. 2010;103(2):111-5

The objective of this study was to explore factors that might contribute to misattribution of mental status changes to psychiatric illness when an elderly patient actually has a delirium (mental status changes due to a medical condition). Records of 900 elderly patients referred to a VA psychiatric inpatient unit and 413 to an inpatient psychiatric team at a public hospital from 2001 to 2007 were reviewed. Cases referred because of symptoms secondary to an unrecognized delirium underwent further analysis of preadmission assessments. Comparisons were made to elderly patients with delirium appropriately admitted to medical units.

Thirty (2.3%) of the patients referred to psychiatric units were found to have a physical disorder requiring medical intervention within twelve hours. Compared to 30 delirious patients admitted to medical units, those inappropriately referred to psychiatric units had significantly lower rates of adequate medical histories, physical examinations, cognitive assessments, and laboratory/radiological studies. Among patients with delirium referred to psychiatric units, 66.7% had a history of mental illness, versus 26.7% of comparable admissions to medical units (chi (7) = 60.00, P < 0.001).

Our findings suggest that elderly patients with delirium admitted to psychiatric units are less likely to undergo complete diagnostic assessments than delirious elderly patients admitted to medical units. Symptoms of delirium appear more likely to be incorrectly attributed to psychiatric illness in patients with a history of mental illness than in patients without such a history. Possible explanations for these findings and suggestions for addressing these issues are offered.

PREDICTORS OF CLINICAL IMPROVEMENT IN A RANDOMIZED EFFECTIVENESS TRIAL FOR PRIMARY CARE PATIENTS WITH PANIC DISORDER

Chavira DA, Stein MB, Golinelli D, Sherbourne CD, Craske MG, **Sullivan G**, Bystritsky A, Roy-Byrne PP

J Nerv Ment Dis. 2009;197(10): 715-21

This study's aim was to prospectively examine and identify a model of demographic, clinical, and attitudinal variables that impact improvement among patients with panic disorder. Subjects were 232 primary care patients meeting criteria for DSM-IV panic disorder. Eligible patients were randomly assigned to a collaborative care intervention or to treatment as usual. Assessments occurred at 3-month intervals during the course of 1 year.

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In final multivariate logistic regression models, patients with higher anxiety sensitivity and higher neuroticism scores at baseline were less likely to show clinical improvement (using a criterion of 20 or less on the Anxiety Sensitivity Index) at 3 months. Those who were non-white, had higher anxiety sensitivity, and higher overall phobic avoidance at baseline were less likely to show clinical improvement at 12 months. A greater understanding of these predictors may help clinicians identify who is at greatest risk for persistent panic-related symptoms and to plan the intensity of interventions accordingly.

RECOVERY CORNER

MENTAL HEALTH RECOVERY AND EVIDENCE-BASED PRACTICES

By Shawn L. Clark, Ph.D.
Local Recovery Coordinator/Staff Psychologist
G.V. (Sonny) Montgomery VA Medical Center

As we continue on the journey of system transformation toward recovery-oriented Mental Health services, the Veterans Administration and the South Central MIRECC have strongly encouraged the usage of evidence-based practices, including evidence-based psychotherapies. By definition, evidence-based practice is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research (Sackett, 1996). Evidence-based psychotherapies are those that have repeatedly demonstrated effectiveness in controlled research studies. Evidence-based practice, including evidence-based psychotherapies, is essentially the integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care.

In 2004, the movement toward the use of evidence-based practices within the Veterans Administration began with the VHA Comprehensive Mental Health Strategic Plan. This led to the development of the Uniform Mental Health Services Handbook that was published in 2008. This handbook outlines the vision for a system that readily provides access to evidence-based care. Additionally, several other government agencies, such as SAMHSA, have encouraged the use of evidence-based practices as a means of promoting recovery. Evidence-based practices have consistently proven to generate positive clinical outcomes for those who have utilized them.

Although developed in a controlled, systematic manner, evidence-based practices are compatible with the mental health recovery model in that they are not intended to be practiced in an inflexible, obligatory fashion but point toward self-awareness, self-determination, and choice, which are central concepts in recovery. Evidence-based practices assist people in mental health recovery by providing them with the tools necessary to manage their illnesses and move forward with their lives.

When recovery-oriented concepts such as partnership and empowerment are essential to successful outcomes. This shared decision-making approach encourages the patient to partner with the therapist in an effort to effect long-term, positive changes in the patient's life. This type of collaboration provides a sense of empowerment that not only helps the Veteran cope with current problems but also facilitates the development of skills that will aid in overcoming potential obstacles in the future.

Currently, there are several evidence-based practices and evidence-based psychotherapies being utilized within the VA for a variety of mental health conditions including posttraumatic stress disorder (PTSD), depression, and serious mental illness (SMI). An overview of the approved treatment modalities is provided below by diagnosis.

PTSD

Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) are the evidence-based practices currently approved for use at VA facilities for patients with PTSD. CPT is a 12-session trauma-focused psychotherapy that can be administered in individual or group sessions.

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CPT consists of three primary components: education about PTSD, thoughts, and emotions; trauma processing; and event-specific cognitive techniques to achieve more balanced thinking about oneself, trauma, others and the world. PE is typically delivered in approximately 10 weekly individual sessions and consists of four basic components including education about reactions to trauma and PTSD, breathing retraining for relaxation, in-vivo exposure and imaginal exposure.

DEPRESSION

Acceptance and Commitment Therapy (ACT) and Cognitive Behavior Therapy (CBT) are evidence-based options for patients with depression. ACT is typically delivered in 12-16 weekly individual sessions but can be offered in an individual or group format. ACT is designed to target harmful experiential avoidance and non-acceptance while encouraging patients to make powerful life enhancing choices that are consistent with their personal values. CBT is delivered in 16 weekly sessions in a structured, time-limited, present-focused approach that helps patients develop new skills, perspective, and strategies to modify dysfunctional thinking patterns, maladaptive emotions and behaviors to assist them in resolving current problems.

SERIOUS MENTAL ILLNESS

One approved evidence-based treatment for Veterans living with SMI is Social Skills Training (SST). This highly structured treatment is aimed at helping Veterans with SMI develop new social skills. The training emphasizes developing specific skills in the areas of basic conversation, assertiveness, conflict management, friendship and dating, health maintenance, work, and coping skills for drug and alcohol use. The goal of treatment is to improve the participant's ability to relate to others.

The two modalities of Family Psychoeducation available to Veterans with SMI and their family members include Multifamily Group Therapy (MFGT) and Behavioral Family (BFT) Therapy. MFGT involves individual consumer and family activities. It consists of an illness education module, after which diagnosis specific, co-led groups of 3-5 consumers and their identified primary supports occur in biweekly sessions over the course of a year. These sessions involve informal socializing to reduce isolation and formal problem solving on issues that hinder recovery. The second modality is Behavioral Family Therapy, in which initial assessments are conducted with each participant to identify specific goals and stressors after which individual family sessions are offered that provide illness education, communication skills instruction, and training in problem-solving. In BFT, there is a strong emphasis on formal skills training utilizing programmed practice.

In summary, the benefits of evidence-based psychotherapies are many in that they can be provided in individual or group formats, treatment length is of relatively brief duration, and some can be effectively provided via tele-medicine modalities. These psychotherapies also have demonstrated effectiveness, are appropriate for use with a wide-range of patients and conditions, and typically have long-term, lasting effects. Evidence-based practices support recovery principles such as shared decision-making and empowerment while instilling hope for the future, which improves quality of life and promotes overall mental health recovery.

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